



# ACCIDENT REPORT

Report No. \_\_\_\_\_

Date: \_\_\_\_\_  
Time: \_\_\_\_\_

**Employee:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: Male Female

Job Title: Mechanical Fitter \_\_\_\_\_ Supervisor Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

**Accident Category:**

- |   |  |
|---|--|
| <input type="checkbox"/> Employee Injury, Illness or Fatality | <input type="checkbox"/> Serious Accident          |
| <input type="checkbox"/> Property Damage                      | <input type="checkbox"/> Chemical Spill or Release |
| <input type="checkbox"/> Near Miss Accident                   | <input type="checkbox"/> Vehicle Accident          |
| <input type="checkbox"/> Explosion or Fire                    | <input type="checkbox"/> Other: _____              |

**Accident Information:**

Accident Date: \_\_\_\_\_ Accident Time: \_\_\_\_\_ Shift: \_\_\_\_\_

Accident Location: Load Compartment

Business Phone: \_\_\_\_\_

Injuries: Steel in the eye \_\_\_\_\_  
 First Aid Only  Lost Time Projected Days Lost: 0  
 Was Proper PPE used?  yes  no Any Problems with PPE?  yes  no  
 If yes Describe: \_\_\_\_\_

Brief Description of Accident (Who, What, Where, When and Why?)

Detailed Sequence of Events: \_\_\_\_\_

**Analysis of Accident Causes:**

Unsafe Acts – What factors contributed to employees actions? Check all that apply.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Job Unaware of Hazard     | <input type="checkbox"/> Inattentive to Hazard                         | <input type="checkbox"/> Unaware of Safe Method      |
| <input type="checkbox"/> Low level of job skill    | <input type="checkbox"/> Influence of Fatigue                          | <input type="checkbox"/> Tried to gain or save time  |
| <input type="checkbox"/> Influence of Illness      | <input type="checkbox"/> Influence of Intoxicants                      | <input type="checkbox"/> Tried to Avoid extra Effort |
| <input type="checkbox"/> Tried to avoid discomfort | <input type="checkbox"/> Physical Condition (i.e. poor vision, injury) |  |
- Other \_\_\_\_\_



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Unsafe Conditions – What conditions (i.e. tools, equipment, work area) contributed to accident? Check all that apply.

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Worn out from normal use | <input type="checkbox"/> Unsafe Design           | <input type="checkbox"/> Abuse of Misuse of Equipment/Tools |
| <input type="checkbox"/> Faulty Construction      | <input type="checkbox"/> Exposed to extreme temp | <input type="checkbox"/> Exposure to vibration              |
| <input type="checkbox"/> Poor Housekeeping        | <input type="checkbox"/> Inadequate Maintenance  | <input type="checkbox"/> Tampering with Equipment           |
| <input type="checkbox"/> Equipment not Inspected  | <input type="checkbox"/> Work area congested     | <input type="checkbox"/> Inadequate Illumination            |
| <input type="checkbox"/> Other: _____             |  |   |

Description of Root Cause(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Corrective Action Plan:**

Corrective Actions Planned Check all that Apply:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Improve Equip Design           | <input type="checkbox"/> Improve Housekeeping  | <input type="checkbox"/> Discipline of Person(s) Involved |
| <input type="checkbox"/> Improve PPE Used               | <input type="checkbox"/> Repair Equipment      | <input type="checkbox"/> Retraining of Person(s) Involved |
| <input type="checkbox"/> Install guard or safety device | <input type="checkbox"/> Modify materials used | <input type="checkbox"/> Modify Work Procedures           |

Describe Corrective Actions:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Schedule, Milestone and Follow Up:

Corrective Action:	Responsible Person:	Projected Date	<input type="checkbox"/>	Completed Yes	Date
_____	_____	_____	<input type="checkbox"/>	_____	_____
_____	_____	_____	<input type="checkbox"/>	_____	_____
_____	_____	_____	<input type="checkbox"/>	_____	_____

**Signatures:**

Investigator (Name): \_\_\_\_\_ (Signature): \_\_\_\_\_

Employee (Name): \_\_\_\_\_ (Signature): \_\_\_\_\_

**Distribution: (Check all applicable boxes)**

- Site Manager \_\_\_\_\_  EHS Manager \_\_\_\_\_
- Project Manager \_\_\_\_\_  Other Services Manager \_\_\_\_\_

**CALL IMMEDIATELY TO REPORT AN INJURY  
THIS FORM MUST BE COMPLETED IN ENTIRETY**